

		FOR OHF USE					

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p>I. IDPH Facility ID Number: <u>0045849</u></p> <p>Facility Name: <u>Astoria Gardens & Rehab Center</u></p> <p>Address: <u>1008 E. Broadway</u> <u>Astoria</u> <u>61501</u> Number City Zip Code</p> <p>County: <u>Fulton</u></p> <p>Telephone Number: <u>(309) 329-1333</u> Fax # <u>(309) 329-1334</u></p> <p>IDPA ID Number: <u>300096391001</u></p> <p>Date of Initial License for Current Owners: <u>8/1/2002</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Allan B. Larson, CPA</u> Telephone Number: <u>(314) 336-3679</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2004</u> to <u>12/31/2004</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td data-bbox="1159 678 1297 824" rowspan="2">Officer or Administrator of Provider</td> <td data-bbox="1297 678 1948 743">(Signed) _____ (Date) _____</td> </tr> <tr> <td data-bbox="1297 743 1948 808">(Type or Print Name) <u>Steve Axelbaum</u></td> </tr> <tr> <td data-bbox="1159 824 1297 1036" rowspan="4">Paid Preparer</td> <td data-bbox="1297 808 1948 873">(Title) <u>Owner</u></td> </tr> <tr> <td data-bbox="1297 873 1948 938">(Signed) _____ (Date) _____</td> </tr> <tr> <td data-bbox="1297 938 1948 1003">(Print Name and Title) <u>Allan B. Larson, CPA</u> <u>Principal</u></td> </tr> <tr> <td data-bbox="1297 1003 1948 1036">(Firm Name & Address) <u>Larson, Allen, Weishair, & Co, LLP</u> <u>12801 Flushing Meadows Drive, Suite 100</u></td> </tr> <tr> <td colspan="2" data-bbox="1159 1036 1948 1117"> (Telephone) <u>(314) 336-3600</u> Fax # <u>(314) 336-3650</u> MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630 </td> </tr> </table>	Officer or Administrator of Provider	(Signed) _____ (Date) _____	(Type or Print Name) <u>Steve Axelbaum</u>	Paid Preparer	(Title) <u>Owner</u>	(Signed) _____ (Date) _____	(Print Name and Title) <u>Allan B. Larson, CPA</u> <u>Principal</u>	(Firm Name & Address) <u>Larson, Allen, Weishair, & Co, LLP</u> <u>12801 Flushing Meadows Drive, Suite 100</u>	(Telephone) <u>(314) 336-3600</u> Fax # <u>(314) 336-3650</u> MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	
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STATE OF ILLINOIS

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Facility Name & ID Number Astoria Gardens & Rehab Center# 0045849 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed bedsN/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>10</u>	Skilled (SNF)	<u>10</u>	<u>3,660</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>59</u>	Intermediate (ICF)	<u>59</u>	<u>21,594</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>69</u>	TOTALS	<u>69</u>	<u>25,254</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>1,072</u>		<u>1,544</u>	<u>2,616</u>	8
9	SNF/PED					9
10	ICF	<u>9,921</u>	<u>3,044</u>		<u>12,965</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>10,993</u>	<u>3,044</u>	<u>1,544</u>	<u>15,581</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 61.70%

D. How many bed-hold days during this year were paid by Public Aid?

0 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)adult day care

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐NO ☒

I. On what date did you start providing long term care at this location?

Date started 8/1/2002

J. Was the facility purchased or leased after January 1, 1978?

YES ☒Date NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒NO ☐

If YES, enter number

of beds certified 10and days of care provided 1,544Medicare Intermediary AdminStar Federal

IV. ACCOUNTING BASIS

ACCRUAL ☒

MODIFIED

CASH* ☐CASH* ☐

Is your fiscal year identical to your tax year?

YES ☒NO ☐Tax Year: 12/31/04 Fiscal Year: 12/31/04

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

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Facility Name & ID Number Astoria Gardens & Rehab Center # 0045849 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	86,326	6,273	5,145	97,744		97,744		97,744		1
2	Food Purchase		62,841		62,841		62,841		62,841		2
3	Housekeeping	50,766	8,381		59,147		59,147		59,147		3
4	Laundry	17,139	4,044		21,183		21,183		21,183		4
5	Heat and Other Utilities			58,716	58,716		58,716	(5,103)	53,613		5
6	Maintenance	26,912	10,759	22,839	60,510	668	61,178		61,178		6
7	Other (specify):*										7
8	TOTAL General Services	181,143	92,298	86,700	360,141	668	360,809	(5,103)	355,706		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	491,153	58,304	2,142	551,599	(37,202)	514,397		514,397		10
10a	Therapy			156,384	156,384		156,384		156,384		10a
11	Activities	13,070	271	1,531	14,872		14,872		14,872		11
12	Social Services	16,678		1,468	18,146		18,146		18,146		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	520,901	58,575	161,525	741,001	(37,202)	703,799		703,799		16
	C. General Administration										
17	Administrative	74,880	1,561	6,645	83,086		83,086	(14,441)	68,645		17
18	Directors Fees										18
19	Professional Services			69,425	69,425	(4,472)	64,953		64,953		19
20	Dues, Fees, Subscriptions & Promotions			5,556	5,556	2,214	7,770	(5,367)	2,403		20
21	Clerical & General Office Expenses	25,169	6,649	16,675	48,493	1,590	50,083	(483)	49,600		21
22	Employee Benefits & Payroll Taxes			129,457	129,457		129,457		129,457		22
23	Inservice Training & Education										23
24	Travel and Seminar			8,081	8,081		8,081	(5,793)	2,288		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			38,792	38,792		38,792		38,792		26
27	Other (specify):*										27
28	TOTAL General Administration	100,049	8,210	274,631	382,890	(668)	382,222	(26,084)	356,138		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	802,093	159,083	522,856	1,484,032	(37,202)	1,446,830	(31,187)	1,415,643		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Astoria Gardens & Rehab Center #0045849 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			9,434	9,434		9,434	65,131	74,565			30
31	Amortization of Pre-Op. & Org.			552	552		552		552			31
32	Interest			18,659	18,659		18,659	72,784	91,443			32
33	Real Estate Taxes			28,615	28,615		28,615		28,615			33
34	Rent-Facility & Grounds			144,000	144,000		144,000	(144,000)				34
35	Rent-Equipment & Vehicles			9	9		9		9			35
36	Other (specify):*											36
37	TOTAL Ownership			201,269	201,269		201,269	(6,085)	195,184			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					37,202	37,202		37,202			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			37,882	37,882		37,882		37,882			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			37,882	37,882	37,202	75,084		75,084			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	802,093	159,083	762,007	1,723,183		1,723,183	(37,272)	1,685,911			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

STATE OF ILLINOIS

Page 5

Facility Name & ID Number Astoria Gardens & Rehab Center

0045849

Report Period Beginning:

1/1/2004

Ending:

12/31/2004

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	1	2	3	
	Amount	Refer-	OHF USE	
NON-ALLOWABLE EXPENSES		ence	ONLY	
1 Day Care	\$		\$	1
2 Other Care for Outpatients				2
3 Governmental Sponsored Special Programs				3
4 Non-Patient Meals				4
5 Telephone, TV & Radio in Resident Rooms	(5,103)	5		5
6 Rented Facility Space				6
7 Sale of Supplies to Non-Patients				7
8 Laundry for Non-Patients				8
9 Non-Straightline Depreciation	(266)	30		9
10 Interest and Other Investment Income				10
11 Discounts, Allowances, Rebates & Refunds				11
12 Non-Working Officer's or Owner's Salary				12
13 Sales Tax				13
14 Non-Care Related Interest				14
15 Non-Care Related Owner's Transactions				15
16 Personal Expenses (Including Transportation)	(5,793)	24		16
17 Non-Care Related Fees				17
18 Fines and Penalties				18
19 Entertainment				19
20 Contributions				20
21 Owner or Key-Man Insurance				21
22 Special Legal Fees & Legal Retainers				22
23 Malpractice Insurance for Individuals				23
24 Bad Debt				24
25 Fund Raising, Advertising and Promotional	(5,367)	20		25
Income Taxes and Illinois Personal				
26 Property Replacement Tax	(483)	21		26
27 Nurse Aide Training for Non-Employees				27
28 Yellow Page Advertising				28
29 Other-Attach Schedule Marketing Director/Supplies	(14,441)	17		29
30 SUBTOTAL (A): (Sum of lines 1-29)	\$ (31,453)		\$	30

OHF USE ONLY						
48		49		50		51
						52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

	1	2	
	Amount	Reference	
31 Non-Paid Workers-Attach Schedule*	\$		31
32 Donated Goods-Attach Schedule*			32
33 Amortization of Organization & Pre-Operating Expense			33
Adjustments for Related Organization			
34 Costs (Schedule VII)	(5,553)		34
35 Other- Attach Schedule			35
36 SUBTOTAL (B): (sum of lines 31-35)	\$ (5,553)		36
(sum of SUBTOTALS			
37 TOTAL ADJUSTMENTS (A) and (B))	\$ (37,006)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.
(See instructions.)

	1	2	3	4	
	Yes	No	Amount	Reference	
38 Medically Necessary Transport.			\$		38
39					39
40 Gift and Coffee Shops					40
41 Barber and Beauty Shops					41
42 Laboratory and Radiology					42
43 Prescription Drugs	x		37,202	10	43
44 Exceptional Care Program					44
45 Other-Attach Schedule					45
46 Other-Attach Schedule					46
47 TOTAL (C): (sum of lines 38-46)			\$ 37,202		47

Astoria Gardens & Rehab Center

ID# 0045849

Report Period Beginning: 1/1/2004

Ending: 12/31/2004

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
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34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Astoria Gardens & Rehab Center

0045849

Report Period Beginning:

1/1/2004

Ending:

12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(5,103)	0	0	0	0	0	0	0	0	0	0	(5,103)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(5,103)	0	0	0	0	0	0	0	0	0	0	(5,103)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(5,367)	0	0	0	0	0	0	0	0	0	0	(5,367)	20
21	Clerical & General Office Expenses	(483)	0	0	0	0	0	0	0	0	0	0	(483)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(5,793)	0	0	0	0	0	0	0	0	0	0	(5,793)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(11,643)	0	0	0	0	0	0	0	0	0	0	(11,643)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(16,746)	0	0	0	0	0	0	0	0	0	0	(16,746)	29

Summary B

12/31/2004

[illegible]

Facility Name & ID Number Astoria Gardens & Rehab Center# 0045849

Report Period Beginning:

1/1/2004

Ending:

12/31/2004

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Steve Axelbaum	50			Astoria Gardens, LLC	Astoria, IL	Real Estate
Jan Axelbaum	50					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V	34 Building/Equipment Rental	\$ 144,000	Astoria Gardens, LLC	100.00%	\$	\$ (144,000) 1
2	V	30 Depreciation				65,663	65,663 2
3	V	32 Interest				72,784	72,784 3
4	V						4
5	V						5
6	V						6
7	V						7
8	V						8
9	V						9
10	V						10
11	V						11
12	V						12
13	V						13
14	Total		\$ 144,000			\$ 138,447	\$ * (5,553) 14

* Total must agree with the amount recorded on line 34 of Schedule VI.

STATE OF ILLINOIS

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Facility Name & ID Number Astoria Gardens & Rehab Center # 0045849 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Steve Axelbaum	Administrator	Administrator	50.00	None	40	100.00		\$ 36,750	17-1	1
2	Jan Axelbaum										2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 36,750		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Astoria Gardens & Rehab Center# 0045849

Report Period Beginning:

1/1/2004Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number (____) _____

Fax Number (____) _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number Astoria Gardens & Rehab Center # 0045849 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$						1
2	Investment Group		x	Operations	none	10/07/04	70,000	65,313	2005	8.0000			2
3	NP - J. Fuhrer & Co.		x	Operations	interest only	03/21/03	25,000		2005	12.0000	4,307		3
4	NP - J. Bubb		x	Operations	interest only	04/01/03	30,000		2004	10.0000	(250)		4
5	NP - US Bank (Astoria Gardens, LLC)		x	Building/Equip			1,200,000				72,784		5
	Working Capital												
6	NP-Astoria Group		x	Working Capital		09/23/03	16,000		2004	5.5000	1,847		6
7	Steve Axelbaum	x		Operations	interest only	08/02	150,000	zero			10,438		7
8													8
9	TOTAL Facility Related						\$ 1,491,000	\$ 65,313				\$ 89,126	9
	B. Non-Facility Related*												
10	Various vendors		x								270		10
11	Insurance Installments		x								1,451		11
12	Real Estate Tax Interest		x								207		12
13	Business Credit Cards		x								389		13
14	TOTAL Non-Facility Related						\$					\$ 2,317	14
15	TOTALS (line 9+line14)						\$ 1,491,000	\$ 65,313				\$ 91,443	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ n/a Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number **Astoria Gardens & Rehab Center**# **0045849**

Report Period Beginning:

1/1/2004

Ending:

12/31/2004**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

<div style="border: 1px solid black; padding: 2px; display: inline-block;"> Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report. </div>																																
1. Real Estate Tax accrual used on 2003 report.		\$ 26,641	1																													
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$ 27,628	2																													
3. Under or (over) accrual (line 2 minus line 1).		\$ 987	3																													
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 27,628	4																													
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5																													
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6																													
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ 28,615	7																													
Real Estate Tax History:																																
Real Estate Tax Bill for Calendar Year:	<table border="1"> <tr><td>1999</td><td></td><td>8</td></tr> <tr><td>2000</td><td></td><td>9</td></tr> <tr><td>2001</td><td></td><td>10</td></tr> <tr><td>2002</td><td>26,752</td><td>11</td></tr> <tr><td>2003</td><td>27,513</td><td>12</td></tr> </table>	1999		8	2000		9	2001		10	2002	26,752	11	2003	27,513	12	<table border="1"> <tr><td colspan="2">FOR OHF USE ONLY</td><td></td></tr> <tr><td>13</td><td>FROM R. E. TAX STATEMENT FOR 2003 \$</td><td>13</td></tr> <tr><td>14</td><td>PLUS APPEAL COST FROM LINE 5 \$</td><td>14</td></tr> <tr><td>15</td><td>LESS REFUND FROM LINE 6 \$</td><td>15</td></tr> <tr><td>16</td><td>AMOUNT TO USE FOR RATE CALCULATION \$</td><td>16</td></tr> </table>	FOR OHF USE ONLY			13	FROM R. E. TAX STATEMENT FOR 2003 \$	13	14	PLUS APPEAL COST FROM LINE 5 \$	14	15	LESS REFUND FROM LINE 6 \$	15	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
1999		8																														
2000		9																														
2001		10																														
2002	26,752	11																														
2003	27,513	12																														
FOR OHF USE ONLY																																
13	FROM R. E. TAX STATEMENT FOR 2003 \$	13																														
14	PLUS APPEAL COST FROM LINE 5 \$	14																														
15	LESS REFUND FROM LINE 6 \$	15																														
16	AMOUNT TO USE FOR RATE CALCULATION \$	16																														

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Astoria Gardens & Rehab Center COUNTY Fulton

FACILITY IDPH LICENSE NUMBER 0045849

CONTACT PERSON REGARDING THIS REPORT Allan Larson

TELEPHONE (314) 336-3679 FAX #: (314) 336-3650

A. Summary of Real Estate Tax Costs

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>24-26-24-140-010</u>	<u>1008 E Broadway Sub Div NW Sec 2</u>	<u>\$ 27,513.22</u>	<u>\$ 27,513.22</u>
2. <u>24-26-24-140-008</u>	<u>1009 E Broadway Sub Div NW Sec 2</u>	<u>\$ 114.76</u>	<u>\$ 114.76</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>27,627.98</u>	\$ <u>27,627.98</u>

B. Real Estate Tax Cost Allocation:

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES x _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used)

C. Tax Bills

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 16,608 B. General Construction Type: Exterior Brick Frame Wood Number of Stories One

C. Does the Operating Entity? ☐ (a) Own the Facility ☒ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? ☒ (a) Own the Equipment ☒ (b) Rent equipment from a Related Organization. ☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground: (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☒ YES ☐ NO
If so, please complete the following:

1. Total Amount Incurred: 2,761 2. Number of Years Over Which it is Being Amortized: 5
3. Current Period Amortization: 552 4. Dates Incurred: 2002

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2					2
3	TOTALS			\$	3

Facility Name & ID Number Astoria Gardens & Rehab Center

0045849

Report Period Beginning:

1/1/2004

Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

1	2	3	4	5	6	7	8	9	
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	69	2002		\$ 1,300,000	\$ 47,273	27.5	\$ 47,273		\$ 112,273
5									
6									
7									
8									
Improvement Type**									
9	Underground wiring for lamp pos	2002		1,151	30	39	30		64
10	Bathroom Fixtures	2004		3,580	426	7	426		426
11	Carpet	2004		243	29	7	29		29
12	Floor Tile	2004		1,093	130	7	130		130
13	Public Health Modifications (Fire Walls & Ceiling Tiles)	2004		15,727	262	15	262		262
14	Wallpaper and application	2004		1,127	75	15	75		75
15	2 stained glass windows	2004		250	17	15	17		17
16	Paint	2004		500	33	15	33		33
17	Interior Decorator	2004		3,269	118	15	118		118
18	Architect for bathrooms	2004		576	38	15	38		38
19	Interior doors	2004		803	54	15	54		54
20	Call light system and installation	2004		562	37	15	37		37
21	Drywalling	2004		1,655	55	15	55		55
22	Bathrooms and labor	2004		2,295	75	15	75		75
23	Wood, steel studs, wall bases, trim and labor for installation	2004		8,487	366	15	366		366
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
36									

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,341,318	\$ 49,018		\$ 49,018	\$	\$ 114,052	70

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Astoria Gardens & Rehab Center

0045849

Report Period Beginning:

1/1/2004

Ending:

12/31/2004

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 129,991	\$ 24,162	\$ 24,162	\$	various	\$ 62,369	71
72	Current Year Purchases	12,662	1,051	1,051		various	1,051	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 142,653	\$ 25,213	\$ 25,213	\$		\$ 63,420	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Maintenance & Co. errands	1988 Ford Club Wagon Van	2003	\$ 3,000	\$ 600	\$ 600	\$	5	\$ 900	76
77										77
78										78
79										79
80	TOTALS			\$ 3,000	\$ 600	\$ 600	\$		\$ 900	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,486,971	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 74,831	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 74,831	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 178,372	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Barn	\$ 5,068	\$ 130	\$ 135	86
87	Sidewalk to Barn	440	29	32	87
88	Drive for Barn	780	35	35	88
89	Barn Fence	348	15	15	89
90	Completion of Barn	3,311	57	57	90
91	TOTALS	\$ 9,947	\$ 266	\$ 274	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Astoria Gardens, LLC

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		<u>69</u>	<u>8/1/02</u>	\$ <u>144,000</u>	<u>5</u>	<u>10</u>	3
4	Additions							4
5								5
6								6
7	TOTAL		69		\$ 144,000			7

8. List separately any amortization of lease expense included on page 4, line 34. _____

This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.

9. Option to Buy: ☐ YES ☒ NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☒ YES ☐ NO

16. Rental Amount for movable equipment: \$ 2,142 Description: storage/dishwasher/auger/tables & chairs/helium tank for activities/misc medical equipment
(Attach a schedule detailing the breakdown of movable equipment)

10. Effective dates of current rental agreement:

Beginning 8/1/02
Ending 7/31/07

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. 12/31/2005 \$ 144,000
13. 12/31/2006 \$ 144,000
14. 12/31/2007 \$ 144,000

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

* If there is an option to buy the building,
please provide complete details on attached
schedule.

** This amount plus any amortization of lease
expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE _____	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER AIDE _____
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ _____

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$ 63,552	\$		\$ 63,552	1
2	Licensed Speech and Language Development Therapist		hrs			4,020			4,020	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			88,812			88,812	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$		\$ 156,384	\$		\$ 156,384	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 5,937	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	370,959		3
4	Supply Inventory (priced at)	4,767		4
5	Short-Term Investments			5
6	Prepaid Insurance	3,191		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 384,854	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	51,266		15
16	Equipment, at Historical Cost	45,653		16
17	Accumulated Depreciation (book methods)	(13,160)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Organizational Costs	1,427		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 85,186	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 470,040	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 235,766	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	43,891		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	27,628		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to Related Party	91,111		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 398,396	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	65,313		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 65,313	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 463,709	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 6,331	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 470,040	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (77,677)	1
2	Restatements (describe):		2
3	Prior year tax depreciation	25,877	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (51,800)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	58,131	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 58,131	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 6,331	24

*

* This must agree with page 17, line 47.

STATE OF ILLINOIS

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Facility Name & ID Number Astoria Gardens & Rehab Center

0045849

Report Period Beginning: 1/1/2004

Ending: 12/31/2004

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 1,857,290	1
2	Discounts and Allowances for all Levels	(186,161)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,671,129	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	109,732	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 109,732	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio	240	15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	(15)	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 225	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	189	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 189	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous	39	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 39	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,781,314	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	360,141	31
32	Health Care	741,001	32
33	General Administration	382,890	33
	B. Capital Expense		
34	Ownership	201,269	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	37,882	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,723,183	40
41	Income before Income Taxes (line 30 minus line 40)**	58,131	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 58,131	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

**** Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Astoria Gardens & Rehab Center

0045849

Report Period Beginning: 1/1/2004

Ending:

12/31/2004

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,706	1,848	\$ 44,211	\$ 23.92	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,891	3,030	59,043	19.49	3
4	Licensed Practical Nurses	5,842	6,014	92,482	15.38	4
5	Nurse Aides & Orderlies	25,236	26,276	253,696	9.66	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	343	358	3,518	9.83	8
9	Activity Director	1,421	1,445	12,868	8.91	9
10	Activity Assistants	37	37	202	5.46	10
11	Social Service Workers	1,406	1,436	16,678	11.61	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	6,509	6,725	60,422	8.98	14
15	Cook Helpers/Assistants	3,630	3,723	25,904	6.96	15
16	Dishwashers					16
17	Maintenance Workers	1,932	2,015	26,912	13.36	17
18	Housekeepers	6,480	6,673	50,766	7.61	18
19	Laundry	2,050	2,101	17,139	8.16	19
20	Administrator	2,112	2,112	52,900	25.05	20
21	Assistant Administrator	520	520	9,100	17.50	21
22	Other Administrative					22
23	Office Manager	1,684	1,811	25,169	13.90	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	252	259	3,786	14.62	31
32	Other Health Care Plan Coordinators	1,948	2,038	34,417	16.89	32
33	Other(specify) Marketing	998	1,016	12,880	12.68	33
34	TOTAL (lines 1 - 33)	66,997	69,437	\$ 802,093 *	\$ 11.55	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	119	\$ 5,145	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		1,372	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	26	1,413	11-3	44
45	Social Service Consultant	22	1,468	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	167	\$ 9,398		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				Ownership		D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	%	Amount	Description		Amount	Description	Amount			
Steve Axelbaum	Administrator	50	\$ 36,750	Workers' Compensation Insurance	\$		IDPH License Fee	\$			
Vickie Hamm	Administrator	0	8,320	Unemployment Compensation Insurance			Advertising; Employee Recruitment				
Dawn Gossage	Administrator	0	7,830	FICA Taxes			Health Care Worker Background Check				
Paula Taylor	Asst. Administrator	0	9,100	Employee Health Insurance		1,560	(Indicate # of checks performed _____)				
Rosalie Barrett	Marketing Director	0	12,880	Employee Meals			Dues and Subscriptions	189			
				Illinois Municipal Retirement Fund (IMRF)*			Advertising and Promotion	5,367			
				Miscellaneous Employee Benefits		235	Reclass from prof services				
				HR Advertising		851	for internet subscription and				
				Corp Resource Mgmt (incl FICA/FUTA/SUTA)		126,811	filing fees	2,214			

* Attach copy of IMRF notifications

****See instructions.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

[illegible]

Facility Name & ID Number Astoria Gardens & Rehab Center

STATE OF ILLINOIS

0045849

Report Period Beginning: 1/1/2004

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Ending: 12/31/2004

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. n/a
- (3) Did the nursing home make political contributions or payments to a political organization? No If YES, have these costs been properly adjusted out of the cost report? n/a
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? _____
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? n/a-1st If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. n/a
- (9) Are you presently operating under a sublease agreement? _____ YES x NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO x If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over n/a
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 37,882
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit: on Schedule V. \$ n/a Has any meal income been offset against related costs? n/a Indicate the amount. \$ n/a
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? n/a
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ n/a
c. What percent of all travel expense relates to transportation of nurses and patients? n/a
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? n/a
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: n/a The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? n/a If no, please explain. n/a
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? n/a
Attach invoices and a summary of services for all architect and appraisal fees.